



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

NUEVA VIDA BEHAVIORAL HEALTH AND ASSOC.

**Respondent Name**

STATE OFFICE OF RISK MANAGEMENT

**MFDR Tracking Number**

M4-14-3208-01

**Carrier's Austin Representative**

Box Number 45

**MFDR Date Received**

JUNE 23, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "On 9/09/13, Licensed Professional Counselor, Andrea Zuflacht, M.S., L.P.C. (Nueva Vida Behavioral Clinical Director) met with [Claimant's] treating physician Dr. Ann Pham, DC., Shawna Carreon, and Erica Contreras BA., to coordinate his plan of care."

**Amount in Dispute:** \$112.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Office performed an in-depth review of the dispute packet...and will maintain its denial for W2."

**Response Submitted By:** SORM

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2013 January 6, 2014 February 3, 2014 March 3, 2014	CPT Code 99361 Case Management Services	\$28.00/each	\$0.00
TOTAL		\$112.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W2-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.

- Provider can only have a meeting every 30 days and the people attending the meeting cannot be employed at the same facility. Per Rule 134.204(e)(1)(B) Team Conference and telephone calls must be outside an interdisciplinary program and can not have team members that are employed at the same facility.
- W3-Additional payment made on appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

### **Issues**

Did the requestor support billing the medical conference in accordance with 28 Texas Administrative Code §134.204? Is the requestor entitled to reimbursement?

### **Findings**

The respondent denied reimbursement for the case management services, CPT code 99361, based upon reason code "W2."

28 Texas Administrative Code §134.204(e)(1)(B) states "Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call."

A review of the submitted CASE MANAGEMENT NOTE reports finds that the requestor noted on the CASE MANAGEMENT NOTE reports that the "General Purpose: Care Coordination X." Under the heading "Specific Purpose: Coordinating Care X Clarifying/altering previous instructions X."

The respondent states "The Office performed an in-depth review of the disputed charges and claim fine and concluded that Dr. Anh Pham who is the documented treating doctor for [Claimant] *does not* document in their medical records (Exhibit A) either prior to or after date of service 9/9/2013 that they had attended this meeting nor the reason and/or change in the injured employees condition that warranted case management services. There were no further follow up appointments before or after dates of service 1/6/2014-3/3/2-14."

28 Texas Administrative Code §134.204(e)(2) states: "Case Management Responsibilities by the Treating Doctor is as follows: Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee."

28 Texas Administrative Code §134.204(e)(4) states "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361.

(i) Reimbursement to the treating doctor shall be \$113. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP shall be \$28 when a HCP contributes to the case management activity."

Review of the submitted CASE MANAGEMENT NOTE reports finds that the requestor listed the participants in the conference. The documentation does not support that the case management was triggered by a documented change in the injured employee's condition per by 28 Texas Administrative Code §134.204(e)(2). As a result, reimbursement is not recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	03/05/2015 _____ Date
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## YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**